

Health Care Reform

LEGISLATIVE BRIEF

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Defined Contribution Health Plans

Under a defined contribution health plan, an employer gives its employees a fixed contribution to purchase health insurance coverage. Employees use that money to buy or help pay for a health insurance plan they select for themselves. The concept of a defined contribution employee benefit is not new; most employees are familiar with the defined contribution approach through their retirement benefits. However, recently there has been an increased interest in the defined contribution approach to health benefits.

The heightened interest in defined contribution health plans is mainly due to the increasing costs of health coverage and changes made by the health care reform law, or the Affordable Care Act (ACA). Also, in addition to the public health insurance Exchanges created by the ACA, private exchanges have emerged as marketplaces for employees to select a health plan from an array of available options.

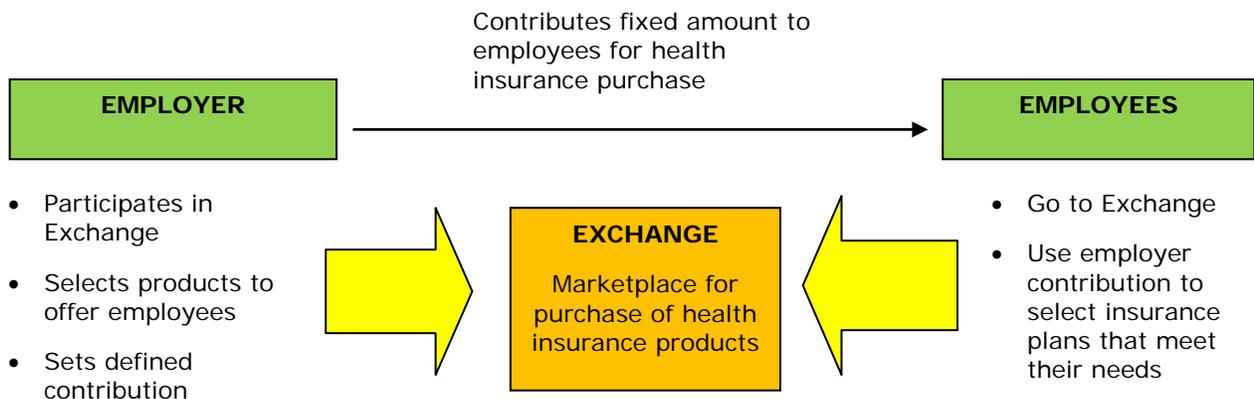
Because defined contribution health plans are a relatively new trend, it is not yet clear whether employees will find this arrangement acceptable and whether it will be a competitive advantage or disadvantage in the employer's labor market.

Also, employers considering a defined contribution health plan should keep in mind that **all employer arrangements that pay or reimburse employees for individual health insurance premiums violate the ACA's market reforms**, regardless of whether the employer treats the money as pre-tax or post-tax for the employee.

This Legislative Brief summarizes the defined contribution approach to employer-sponsored health coverage and includes information on the ACA's impact on defined contribution health plans.

OVERVIEW OF DEFINED CONTRIBUTION APPROACH

The following is a conceptual overview of the defined contribution health plan model:



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The defined contribution approach gives employees more choice and responsibility when choosing health coverage. It also allows the employer to limit its financial contribution for employees' health coverage to a fixed amount, which moves the risk of premium increases to its employees. However, some employees may be skeptical about the defined contribution approach and may prefer the traditional model of health coverage. This could put an employer at a disadvantage in the marketplace if its competitors continue to offer traditional health coverage for their employees.

EMPLOYER CONTRIBUTIONS

HRAs

To maximize tax savings under a defined contribution health plan, employers have typically established **health reimbursement accounts (HRAs)** for making their contributions. Unlike health flexible spending accounts (FSAs) and health savings accounts (HSAs), HRAs can be used to reimburse health insurance premiums. Also, unlike an HSA, an individual does not need to be covered under a high-deductible health plan (HDHP) to participate in an HRA. This has made HRAs particularly compatible with defined contribution health plans.

Effective for 2014, the ACA prohibits all annual limits on essential health benefits. Whether an HRA will be permitted under the ACA's annual limit rules mainly depends on whether the HRA is an "integrated HRA" or a "stand-alone HRA."

Integrated HRAs

An HRA integrated with other group health coverage is not required to satisfy the ACA's annual limit restrictions if the other coverage alone satisfies the annual limit restrictions.

On Sept. 13, 2013, the Internal Revenue Service (IRS) issued [Notice 2013-54](#) (Notice), which provides guidance on when an HRA may be integrated with other group health coverage. This guidance is effective for plan years beginning on or after Jan. 1, 2014, although it may be applied for all prior periods.

The Notice includes two ways for an HRA to be considered integrated with a group health plan for purposes of the annual dollar limit prohibition. In general, an HRA is considered integrated with an employer's group health coverage if, under the terms of the HRA, the HRA is available only to employees who are enrolled in non-HRA group health plan coverage and some additional requirements are met. Under either integration method, the HRA and the other group coverage are not required to have the same plan sponsor, the same plan document or file a single Form 5500 (if applicable).

The Notice also confirms that an HRA used to purchase coverage on the individual market cannot be integrated with that individual market coverage for purposes of the ACA's annual dollar limitation. Thus, an HRA cannot be integrated with individual coverage purchased inside or outside of an Exchange for purposes of satisfying the ACA's annual limit requirements.

Stand-alone HRAs

Some stand-alone HRAs are not subject to the ACA's annual limit restrictions because they fall under an exception, such as retiree-only HRAs. However, beginning in 2014, stand-alone HRAs that do not fall under an exception will not be permitted due to the ACA's prohibition on annual limits.

Cafeteria Plans

Another way for employers to maximize tax savings is to make their employee health insurance contributions through a Section 125 Plan, or a **cafeteria plan**. Employers can offer the employees "credits," or employer money, under a cafeteria plan that can be used to purchase qualified benefits, such as major medical insurance.

Under the ACA, individual health coverage offered through an Exchange generally cannot be reimbursed or paid for under a cafeteria plan. The Notice provided a transition rule for certain cafeteria plans for plan years beginning before Jan. 1, 2014. For cafeteria plans that, as of Sept. 13, 2013, operated on a plan year other than a calendar year, this

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restriction on purchasing individual Exchange coverage through a cafeteria plan did not apply before the first plan year that began after Dec. 31, 2013.

Exchange coverage may be funded through a cafeteria plan if the employee's employer is eligible to participate in the Exchange and elects to make group coverage available.

Also, the Notice indicates that, effective for 2014, cafeteria plans may not be used to pay premiums for individual health insurance policies purchased in the private market that provide major medical coverage. Thus, the tax exclusion provided through a cafeteria plan is only available when group coverage is purchased.

Additional Guidance Prohibiting the Payment of Individual Premiums

On Nov. 6, 2014, the Departments of Labor, Health and Human Services and the Treasury (Departments) issued [FAQs](#) prohibiting all employer arrangements that reimburse employees for individual premiums, whether employers treat the money as pre-tax or post-tax for employees. According to the Departments, these arrangements violate the ACA's market reforms and may trigger an excise tax of \$100 per day for each applicable employee.

MARKETPLACES FOR COVERAGE

Public Exchanges

Effective Jan. 1, 2014, the ACA requires each state to have an Exchange to provide a competitive marketplace where individuals and small businesses will be able to purchase affordable private health insurance coverage. The Department of Health and Human Services (HHS) operates a federally-facilitated Exchange (FFE) in any state that did not establish its own Exchange.

Individuals and small employers with up to 100 employees will be eligible to participate in the Exchanges. However, states may limit employers' participation in the Exchanges to businesses with up to 50 employees until 2016. Beginning in 2017, states may allow businesses with more than 100 employees to participate in the Exchanges.

Each Exchange has a Small Business Health Options Program (SHOP) to allow eligible small employers to provide health insurance for their employees. A SHOP must allow employers the option to offer employees all qualified health plans (QHPs) at a level of coverage selected by the employer—bronze, silver, gold or platinum. This is called the **employee choice model**. In addition, SHOPS may allow an eligible employer to choose one QHP for its employees.

On May, 31, 2013, HHS issued a [final rule](#) that **delayed implementation of the employee choice model** as a requirement for all SHOPS for one year, until 2015. According to HHS, this approach provided all SHOPS (both state and federal) with additional time to prepare for the employee choice model. Under the transition approach:

- *State-based Exchanges:* A state-based Exchange's SHOP may provide the employee choice model for small employers in 2014, but is not required to provide this model until 2015. Many state-run SHOPS began offering employee choice to small employers in 2014, including California, Colorado and New York.
- *FFE:* The federally-facilitated SHOP (FF-SHOP) will not provide the employee choice model for small employers until 2015.

In addition, to smooth the transition to employee choice, HHS allowed state insurance commissioners to request that the SHOP in their state not implement employee choice for 2015. On June 10, 2014, HHS released [a list of FF-SHOP states](#) where the employee choice model will be further delayed. In total, **18 states with an FF-SHOP** will not be providing the employee choice model in 2015. Employers in these states will be able to offer employees a single QHP through the SHOP Exchange. Most state-based Exchanges will have employee choice available to small businesses in 2015.

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Private Exchanges

Private health insurance exchanges are emerging as an alternative to the ACA's public Exchanges. When using a private exchange, employers contract with the exchange, set a defined contribution and select the health insurance products to be offered to employees. Employees then go to the exchange's online marketplace and, using the employer contribution, select a plan from the available options.

Private exchanges can provide more flexibility than the ACA's Exchanges.

- Private exchanges can offer a broader range of insurance products, such as life insurance, and their products can be tailored for different employer segments.
- Although the ACA prohibits large employers from using the Exchanges until at least 2017, there is no similar restriction for private exchanges. Thus, small and large employers can use private exchanges to provide group health insurance benefits to their employees.
- Private exchanges are currently operating to provide employees with a choice of health insurance products, while the SHOP's employee choice model has been delayed in many states.

Private health insurance exchanges are a relatively new model for providing group health insurance benefits. The availability and success of private exchanges most likely depends on employers' willingness to move from a traditional health plan to a defined contribution health plan.

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